

CASE HISTORY

Name _____ Age _____ Date _____ Case Number _____
 Address _____ City _____ State _____ Zip _____
 Phone(Home) _____ Date of Birth _____ Sex: M F Marital Status: S M D W #Children _____
 Occupation _____ Employer _____ Telephone (Work) _____
 Insured's Name _____ Insured's Date of Birth _____
 Spouse's Name _____ Spouse's Occupation _____
 Spouse's Employer _____ Spouse's Telephone (work) _____
 Referred by _____ Past Chiropractic Care Yes No When _____
 Doctor's Name _____ Results _____
 Insurance Company _____ Telephone _____
 Social Security# _____ Driver's License# _____
 Spouse's Insurance Company _____ Telephone _____
 Spouse's Social Security# _____ Spouse's Driver's License# _____

Chief Complaint 1. _____ Duration-(How Long) _____ Previous Episodes _____
 List Current Problems 2. _____ Duration-(How Long) _____ Previous Episodes _____
 3. _____ Duration-(How Long) _____ Previous Episodes _____

Are your present problems due to an injury? No Yes On the job Auto Accident Personal Injury Other _____
 Has the accident been reported? No Yes To Employer Auto Carrier Other _____
 Are you now or have you ever been disabled? (Service or Work)? No Yes When _____
 Have you retained an attorney? No Yes Name & Address _____

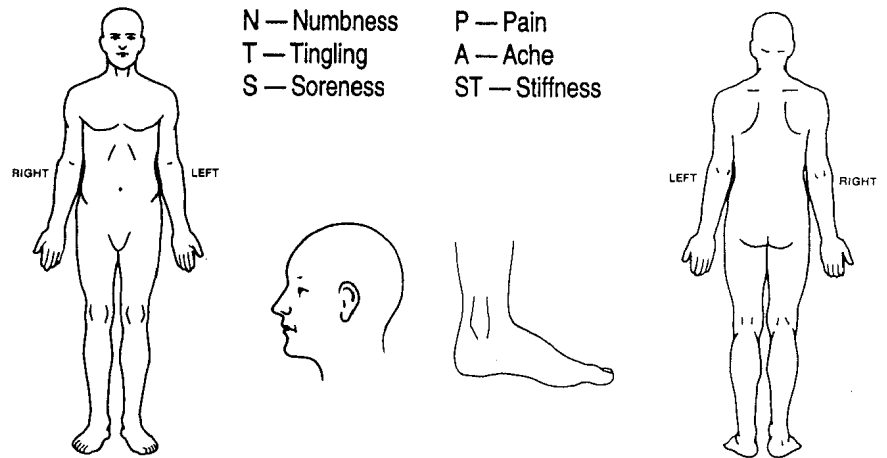
Please mark the intensity of your pain today

1 — NO PAIN
 10 — MOST INTENSE EVER FELT

Example Neck
 1 2 3 4 5 6 7 8 9 10
 (4)

1. _____
 2. _____
 3. _____

Please mark area & type of pain on the drawings using the code listed below.



DOCTORS USE ONLY

HABITS

Smoking Packs/Day _____
 Drinking Alcohol _____
 Coffee Cups/Day _____

EXERCISE

None
 Moderate
 Daily
 Type _____

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother, No. of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister, No. of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> 541 Appendicitis | <input type="checkbox"/> 280 Anemia | <input type="checkbox"/> 429.9 Heart Disease | <input type="checkbox"/> 716 Arthritis |
| <input type="checkbox"/> 480 Pneumonia | <input type="checkbox"/> 055 Measles | <input type="checkbox"/> 240 Goiter | <input type="checkbox"/> 345 Epilepsy |
| <input type="checkbox"/> 390 Rheumatic Fever | <input type="checkbox"/> 072 Mumps | <input type="checkbox"/> 487 Influenza | <input type="checkbox"/> 319 Mental Disorder |
| <input type="checkbox"/> 045 Polio | <input type="checkbox"/> 052 Chicken Pox | <input type="checkbox"/> 511 Pleurisy | <input type="checkbox"/> 724.2 Lumbago |
| <input type="checkbox"/> 011 Tuberculosis | <input type="checkbox"/> 250 Diabetes | <input type="checkbox"/> 305.0 Alcoholism | <input type="checkbox"/> 690 Eczema |
| <input type="checkbox"/> 033 Whooping Cough | <input type="checkbox"/> 239 Cancer | <input type="checkbox"/> 099 Venereal Infection | <input type="checkbox"/> 044 HIV Positive |

Please check the correct box for each item below. Check at least one box for each sign or symptom listed. Never; Previously; Presently.

<table border="0"> <tr> <td style="text-align: center;">Never Previously Presently</td> <td>GENERAL SYMPTOMS</td> <td style="text-align: center;">Never Previously Presently</td> <td>GASTRO-INTESTINAL</td> <td style="text-align: center;">Never Previously Presently</td> <td>EYE/EAR/NOSE/THROAT</td> <td style="text-align: center;">Never Previously Presently</td> <td>RESPIRATORY</td> </tr> <tr> <td><input type="checkbox"/></td> <td>995.3 Allergy (What) _____</td> <td><input type="checkbox"/></td> <td>787.3 Belching or Gas</td> <td><input type="checkbox"/></td> <td>493.9 Asthma</td> <td><input type="checkbox"/></td> <td>786.50 Chest Pain</td> </tr> <tr> <td><input type="checkbox"/></td> <td>_____</td> <td><input type="checkbox"/></td> <td>789.0 Colon Trouble</td> <td><input type="checkbox"/></td> <td>378.9 Crossed Eyes</td> <td><input type="checkbox"/></td> <td>786.2 Chronic Cough</td> </tr> <tr> <td><input type="checkbox"/></td> <td>491 Bronchitis</td> <td><input type="checkbox"/></td> 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OPERATIONS AND PROCEDURES

DATE _____	Vaccinations	DATE _____	Tubes in Ears	DATE _____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gall Bladder	_____	Female Organs	_____	Thyroid
_____	Back Operation	_____	Rectal Surgery	_____	Stomach
_____	Other _____	_____	Other _____	_____	Other _____

I have never had any operations/surgeries.

List any accidents or falls and dates: Car _____ Recreational Vehicle _____
 Sports _____ School _____ Other _____

List any broken bones (fractures) or dislocations : _____
 Ever on crutches? No Yes Why? _____

Have you ever had any spinal taps or spinal injections? Yes No Were you ever knocked unconscious? Yes No

Have you ever had a lapse of memory? Yes No

Have you ever had X-rays taken? No Yes When? _____ By whom? _____

For what ailments were these X-rays made? _____

Do you suffer from any condition other than that for which you are now consulting us? _____

Are you presently taking any medication - prescription or over-the-counter? No Yes What drugs? _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's/Guardian's Signature X _____ Date _____